S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1941

Registration District No. 391

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27486

Primary Registration District No. 1002

Registrar's No. 3144

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 5343 Holmes.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether
In this community — 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town K.C. (If outside city or town limits, write "RURAL")
(d) Street No. 2716 Tracy. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME HINDA FRAM
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased November 10 1885 (Month) (Day) (Year)
8. AGE: Years 55 Months 9 Days 9 If less than one day — hr. — min.
9. Birthplace Skavidle Lithuania (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant Jacob Fram
(b) Address 2716 Tracy
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-41 (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Cem.
18. (a) Signature of funeral director H. Wagner & Sons
(b) Address 2738 Prospect.
19. (a) 8/20/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19 year 1941 hour 11 minute P M.
21. I hereby certify that I attended the deceased from 8-12-41 19— to 8-19-41 19—;
that I last saw her alive on 8-19-41 19—;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to CORONARY	
Due to OCCLUSION	
Other conditions (Include pregnancy within 3 months of death) 94a	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature A. P. Laurenzana (M. D. or other) D
Address 1200 [illegible] Date signed 8-20-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Did not Embalm., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.